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PART II: DEFINITIONS OF ABUSE AND NEGLECT

I. BATTERED CHILD SYNDROME

Battered Child Syndrome refers to a group of symptoms and behaviors exhibited by a child who has been repeatedly physically abused. Battered Child Syndrome is a medicolegal term describing a diagnosis by a medical expert based on scientific studies that when a child suffers certain types of continuing injuries that those injuries were not caused by accidental means. [1] The battered child syndrome "exists when a child has sustained repeated and/or serious injuries by nonaccidental means." [2]

Obvious physical signs are cuts, bruises, broken bones, or burns. Although all of these injuries can easily be caused by accidents, examinations of battered children usually find that the injuries aren't compatible with the account of the accident. The exam may also reveal evidence of past injuries as well. Often, the perpetrator is careful to avoid areas of the child's body that are open to view such as the head and arms. Subsequently, teachers, friends, and others who come into contact with the child may never suspect there is a problem unless they are aware of specific behaviors commonly exhibited by battered children. Watch for surreptitious or manipulative behavior, limited impulse control, angry outbursts, and poor judgment as to what is safe or unsafe. The child may become withdrawn, use drugs or alcohol, do poorly in school, and seem to have no focus or purpose. [3]

II. FAILURE TO THRIVE SYNDROME

A. ORGANIC AND NONORGANIC FAILURE TO THRIVE

Failure to thrive syndrome describes the malnourished and depressed condition of infants, implying not only growth deficits, but also disorders of behavior and development.

1.0 Organic Failure to Thrive

Failure to thrive is used to designate growth failure both as a symptom and as a syndrome. As a symptom, it occurs in patients with a variety of acute or chronic illnesses that are known to interfere with normal nutrient intake, absorption, metabolism, or excretion, or to result in greater-than-normal energy requirements to sustain or promote growth. In these instances, it is referred to as organic FTT.

[1] Black's Law Dictionary, 152 (6th ed. 1990).
[2] *Estelle v. McGuire*, 502 U.S. 62 (1991).
[3] UCSO Healthcare, *Health Guide* "Battered Child Syndrome."

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2.0 Nonorganic Failure to Thrive

Nonorganic failure to thrive is an interactional disorder in which parental expectations, parental skills, and the resulting home environment are intertwined with the child's developmental capabilities. Since the mother is the primary caretaker in most families, this syndrome has been associated with maternal deprivation (see physical neglect-failure to thrive definition) and/or emotional abuse. Failure to thrive syndrome has been referred to as psychosocial dwarfism disorder. It is characterized by physical and developmental retardation associated with a dysfunctional mother – infant relationship. Nonorganic failure to thrive involves the parents' failure to provide nurturance and attachment to the child.

When the term is used to designate a syndrome, it most commonly refers to growth failure in the infant or child who suffers from environmental neglect or stimulus deprivation. It is then designated nonorganic failure to thrive, indicating the absence of a physiologic disorder sufficient to account for the observed growth deficiency.

3.0 Mixed Etiology

Using the most restrictive definition, only those children who were full-term and normally grown at birth and who, by careful investigation, have no congenital or acquired illness are included in the group designated Nonorganic failure to thrive. Organic failure to thrive and nonorganic failure to thrive are not mutually exclusive. There can be children who have growth failure of mixed etiology. This mixed etiology group includes children who were born prematurely but have evidence of disproportionate growth failure in later infancy; children who have or have had some defect that cannot sufficiently explain the current growth failure (e.g., successful cleft palate repair in the past); and children who are frustrating (e.g., because of a neurologically impaired suck) or extremely aversive (e.g., because of a deformity) to the care giver.

4.0 Inadequate Causes

In failure to thrive of any etiology, the physiologic basis for impaired growth is inadequate nutrition to support weight gain. In nonorganic failure to thrive, lack of food may be due to impoverishment, poor understanding of feeding techniques, improperly prepared formula, or inadequate supply of breast milk.

The psychologic basis for nonorganic failure to thrive appears to be similar to that seen in hospitalism, a syndrome observed in infants kept in sterile environments who suffer from depression secondary to stimulus deprivation. The nonstimulated child becomes depressed, apathetic, and ultimately anorexic. The unavailability of the stimulating

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person (usually, the mother) may be secondary to that person's own depression, poor parenting skills, anxiety in or lack of fulfillment from the caretaking role, sense of hostility toward the child, or response to real or perceived external stresses (demands of other children, marital dysfunction, a significant loss, or financial difficulties).

Nonorganic failure to thrive may be considered the result of a disordered interaction between mother and child in which the child's temperament, capacities, and responses help shape maternal nurturance patterns. Failure to thrive is not necessarily the effect of poor care giving by an inadequate or troubled mother. Nonorganic failure to thrive can be the result of a variety of interactional disorders ranging from the severely disturbed or ill child, whose care poses a major challenge to even the most competent parent, to the potentially most undemanding and compliant child being cared for by a mentally ill parent without adequate social, emotional, financial, cognitive, or physical resources. Within these extremes are maternal-child "misfits" in which the demands of the child, although not pathologic, cannot be adequately met by the mother, who might, however, do well with a child of different needs or even with the same child but under different life circumstances.

B. CHARACTERISTICS OF FAILURE TO THRIVE

1.0 Appearance

a. Short stature (height and weight consistently fall fellow the third percentile on the Standard Growth Chart;

b. Unusually thin;

c. Infantile proportions;

d. Potbelly (with episodes of diarrhea);

e. Skin dull, pale, and cold;

f. Limbs pink or purple, cold and mottled;

g. Edema of the feet, legs, hands, and forearms;

h. Poor skin care, excoriations, abrasions, and ulcers;

i. Sparse, dry hair with patches of alopecia (hair loss);

j. Dejection (avoid personal contact) and apathy (avoid eye contact);

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k. May have bruises, small cuts, burns or scars (appear to be insensitive to pain and have self inflicted injuries).

2.0 Behavior

a. Passive with or without catatonia;

b. Rocking or head banging;

c. Retarded speech and language;

d. Delayed development;

e. Solitary and unable to play;

f. Insomnia and disrupted sleep;

g. Easily bullied;

h. Gorging food and scavenging from garbage cans, wastebaskets, toilet bowl, or dog/cat dish.

(Note: During their convalescent stay in a hospital, they have marked growth spurts that relapse as soon as they return to their home environment."

3.0 Progress in the Hospital

a. Rapid recover of growth and liveliness;

b. Slower progress with speech and language;

c. Affection seeking, but may be casual or indiscriminate;

d. Attention seeking;

e. Severe tantrums at the slightest frustration;

f. Rocking and head banging when upset;

g. Continues to want to eat and drink more than can reasonably consume and may scavenge food.

4.0 Long-Term Behaviors

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a. Speech and language immaturity;

b. Gorging of food that may last six months or more;

c. Restlessness with short attention span;

d. Rocking and head banging if stressed;

e. Difficulties with peer group and learning in school;

f. Soiling and wetting (encopretic and enuretic);

g. Stealing and lying;

h. Tantrums and aggression.

INVESTIGATING ALLEGATION INVOLVING SUSPECTED FAILURE TO THRIVE SYNDROME

Nonorganic failure to thrive requires a medical diagnosis. Organic failure to thrive has to be ruled out. During the investigation, the worker should gather as much information as possible about the child and pass it on to the examining physician.

BASIS OF MEDICAL DIAGNOSIS

Engaging the parents in the search for the basis of the problem and its treatment is essential and helps to foster their self-esteem. This avoids blaming those who may already feel frustrated or guilty because of an inability to perform the most basic of parental roles—adequate nurturance of their child. The family should be encouraged to visit as often and as long as possible. They should be made to feel welcome and the staff should support their attempts to feed the child, provide toys as well as ideas that promote parent-child play and other interactions, and avoid any comments that state or imply parental inadequacy, irresponsibility, or other fault as the cause of the failure to thrive.

Child's Growth History

The growth chart, including measurements obtained at birth if possible, should be examined to determine the child's trend in growth rate. Except in severe cases where malnutrition is obvious, the diagnosis of FTT should not be based on a single measurement, because of the wide variations existing in the normal population.

The Child's Dietary History

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A detailed dietary history is essential, including techniques for preparation and feeding of formula or adequacy of breast milk supply, and feeding schedule. Observation of the primary care givers feeding the infant to evaluate their technique as well as the child's vigor of sucking should be undertaken as soon as possible. Easy fatigability may indicate underlying exercise intolerance; enthusiastic burping or rapid rocking during feeding may result in excessive spitting up or even vomiting; disinterest on the part of the care giver may be a sign of depression or apathy, indicating a psychosocial environment for the infant that is devoid of stimulation and interaction.

An assessment of the child's elimination pattern to determine abnormal losses through urine, stool, or emesis should be undertaken to investigate underlying renal disease, a malabsorption syndrome, pyioric stenosis, or gastroesophageal reflux.

Past Medical History

Past medical history inquiries should be directed toward evidence of intrauterine growth retardation or prematurity with uncompensated growth delay; of unusual, prolonged, or chronic infection; of neurologic, cardiac, pulmonary, or renal disease; or of possible food intolerance.

Family History

The family history should include information about familial growth patterns, especially in parents and siblings; the occurrence of diseases known to affect growth (e.g., cystic fibrosis); or recent physical or psychiatric illness that has resulted in the infant's primary care giver being unavailable or unable to provide consistent stimulation and nurturance.

Social History

The social history should include attention to family composition; socioeconomic status; desire for this pregnancy and acceptance of the child; parental depression; and any stresses such as job changes, family moves, separation, divorce, deaths, or other losses. Infants in large or chaotic families or infants who are unwanted may be relatively neglected because of the demands of other children, life events, or parental apathy; financial difficulties may result in over dilution of formula to "stretch" the meager supply; breast-feeding mothers who are under stress or are poorly nourished themselves may have decreased milk production.

Physical Examination

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Physical examination should include careful observation of the child's interaction with individuals in the environment and evidence of self-stimulatory behaviors (rocking, head banging). Children with Nonorganic FTT have been described as hyper vigilant and wary of close contact with people, preferring interactions with inanimate objects if they are interactive at all. Although Nonorganic FTT is more consistent with neglectful than abusive parenting, the child should be examined carefully for any evidence of abuse. A screening test of developmental level should be performed and followed up with a more sophisticated development assessment if indicated.

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Munchausen Syndrome by Proxy

Munchausen syndrome by proxy in adults is "a condition characterized by habitual presentation for hospital treatment of an apparent acute illness, the patient giving a plausible and dramatic history, all of which is false." [4] "Munchausen syndrome by proxy occurs when a parent or guardian falsifies a child's medical history or alters a child's laboratory test or actually causes an illness or injury in a child in order to gain medical attention for the child which may result in innumerable harmful hospital procedures." [5] Munchausen syndrome by proxy involves an apparent deeply caring caretaker who repeatedly fabricates symptoms or provokes actual illnesses in her helpless infant or child.

Maybe the most important aspect of this syndrome is the immense ability of the caretaker to fool doctors and the susceptibility of physicians to that person's manipulations. The hospital, which is the most common setting for Munchausen syndrome by proxy cases, is where as much as 75% of the Munchausen syndrome by proxy related morbidity occurs as a consequence of attempts by physicians to diagnose and treat the affected child or infant. More than 98% of Munchausen syndrome by proxy cases involve female perpetrators.

Commonly Fabricated Illnesses and Symptoms

The most common fabrications or modes of symptom inducement in Munchhausen syndrome by proxy involve seizures, failure to thrive, vomiting and diarrhea, asthma and allergies and infections.

Indicators for Suspecting and Identifying Munchausen Syndrome by Proxy

A child who has one or more medical problems that do not respond to treatment or that follow an unusual course that is persistent, puzzling and unexplained.

Physical or laboratory findings that are highly unusual, discrepant with history, or physically or clinically impossible.

A parent, usually the mother, who appears to be medically knowledgeable and/or fascinated with medical details and hospital gossip, appears to enjoy the hospital environment, and expresses interest in the details of other patients' problems.

[4] Dorland's Illustrated Medical Dictionary 1295 (26th ed. 1981).
[5] Zumwalt & Hirsh, *Pathology of Fatal Child Abuse and Neglect*, Child Abuse and Neglect 276 (R. Helfer & Kempe eds., 4th ed. 1987).

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A highly attentive parent who is reluctant to leave her child's side and who herself seems to require constant attention.

A parent who appears to be unusually calm in the face of serious difficulties in her child's medical course while being highly supportive and encouraging of the physician, or one who is angry, devalues staff, and demands further intervention, more procedures, second opinions, and transfers to other more sophisticated facilities.

The suspected parent may work in the health care field herself or profess interest in a health-related job.

The signs and symptoms of a child's illness do not occur in the parent's absence (hospitalization and careful monitoring may be necessary to establish this casual relationship).

A family history of similar sibling illness or unexplained sibling illness or death.

A parent with symptoms similar to her child's own medical problems or an illness history that itself is puzzling and unusual.

A suspected parent with an emotionally distant relationship with her spouse; the spouse often fails to visit the patient and has little contact with physicians even when the child is hospitalized with serious illness.

A parent who reports dramatic, negative events, such as house fires, burglaries, car accidents, that affect her and her family while her child is undergoing treatment.

A parent who seems to have an insatiable need for adulation or who makes self-serving efforts at public acknowledgment of her abilities.

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Sexual Abuse

The information below is compiled from articles and medical journals listed in the bibliography. The information is not intended to be comprehensive. If further information or clarification is needed consult a physician or the sources listed in the bibliography.

A. Physical Examinations for Possible Sexual Abuse

A normal physical examination is common in child sexual abuse. An absence of physical findings in sexually abused children can be explained in a number of ways. Many types of sexual molestation do not involve penetration and will not leave physical findings. Evidence of ejaculate may not be present if the child has washed, urinated, or defecated and if more than 72 hours has elapsed since the assault. The hymen is elastic and penetration by a finger or penis, especially in an older child, may cause no injury or may only enlarge the hymenal opening. Moreover, injuries can heal rapidly. Hymenal healing occurs in 6 to 30 days and can be complete. Partial hymenal tears can heal as soon as 9 days after injury, while extensive tears may take up to 24 days to heal.

1.0 Medical Categorization of the Physical Examination for Sexual Abuse

Medical professionals commonly will classify the findings of the physical examination into one of four categories:

Category I: Normal Appearing Genitalia. The majority (60% or more) of abused children fall into this category.

Category II: Nonspecific Findings. Abnormalities of the genitalia that could have been caused by sexual abuse but are also seen in girls who are not victims of sexual abuse. Included in this category are redness or inflammation of the external genitalia, increased vascular pattern of the vestibular and labia mucosa, presence of purulent discharge from the vagina, small skin fissures or lacerations in the area of the posterior fourchette, and agglutination of the labia minora. Nonspecific Findings are often seen in children who have not been sexually abused.

Category III: Specific Findings. The presence of one or more abnormalities strongly suggesting sexual abuse. Such findings include recent or healed lacerations of the hymen and vaginal mucosa, hymenal opening of one or more centimeters, proctoepisiotomy (a laceration of the vaginal mucosa extending to involve the rectal mucosa) and indentations on the vulvar skin indicating teeth marks (bite marks). This category also includes patients with laboratory

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confirmation of a venereal disease (e.g., gonorrhea). Category III is suspicious or highly suspicious for sexual abuse.

Category IV: Definitive Findings. Any presence of sperm or sexually transmitted disease. Category IV is conclusive of sexual abuse, especially with children under 12 years of age. Older children may be sexually active.

2.0 Classification of Physical Findings in Sexual Abuse Examinations

Specific physical findings are strongly indicative of sexual abuse beyond reasonable doubt as follows:

a. Clear-cut tears, fresh or old scars; significant distortion of the normal shape of the hymen and/or hymenal bruising;

b. Lacerations, scars, bruises, and healing abraded areas, often accompanied by neovasularization, of the posterior fourchette;

c. Anal dilation greater than 15 mm transverse diameter with gentle buttock traction with the child in knee-chest position. Large anal scars in the absence of a history that could explain the scars.

C. POSSIBLE PHYSICAL INDICATORS IN SEXUALLY ABUSED GIRLS

Certain types and locations of hymenal injuries are often seen after sexual abuse. The hymenal membrane at its midline (6 o'clock position) attachment along the posterior rim of the introitus, during actual or attempted penetration, is the portion of the hymen most likely to be damaged. A narrowed (attenuated) hymen at this position is usually indicative of an injury. Mounds, projections, or notches on the edge of the hymen and the exposure of intravaginal ridges increase the possibility of abuse. Generally, attempted forced vaginal penetration results in hymenal tears and fissures between the 3 and 9 o'clock positions and may extend across the vestibule and fourchette. Other physical signs indicating abuse include:

1.0 Erythema, Inflammation, and Increased Vascularity

In sexual abuse cases, redness of the skin or mucous membranes due to congestion of the capillaries. Normal vaginal mucosa has a pale pink coloration.

2.0 Increased Friability

A small dehiscence (or breakdown) of the tissues of the posterior fourchette may be precipitated by the examination, with occasional oozing of blood. This is usually

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associated with labial adhesions. When the adherent area is large, greater than 2 mm, the suspicion of abuse should be greater.

3.0 Angulation of the Hymenal Edge

There may be V-shaped or angular configuration of the edge of the hymen. The hymenal edge should be smooth and round. Angulation often marks a healed old injury.

4.0 Labial Adhesions

Although labial adhesions are a nonspecific finding often seen in girls with no history of sexual abuse, they may also be a manifestation of chronic irritation and can be seen in children who have been abused.

5.0 Urethral Dilation

Urethral dilation may be an abnormal physical finding in sexually abused girls. Mild to moderate urethral dilation is probably normal, although higher grades may be considered a manifestation of sexual abuse, probably the result of digital manipulation of the urethral orifice.

6.0 Hymenal or Vaginal Tear

Deep breaks in the mucosa of the vagina and hymen are referred to as tears. These injuries can be seen with accidental injuries as well as with abuse. Often they occur when a history of impaling is given.

Genital injuries should be considered abuse until proven otherwise. The bony pelvis and labia usually protects the hymen from accidental injury. Straddle injuries from falls onto a pointed object, the object rarely penetrates through the hymenal orifice into the vagina. A violent stretching injury, as seen when a child does a sudden, forceful split on a slippery surface, can cause midline lacerations. These injuries can also be caused during sexual abuse by forceful, sudden abduction of the legs.

7.0 Discharge

Vaginal secretions are of various consistencies, colors and odors. The usual cause of vaginal discharge in a nonspecific vaginitis. Nonspecific vaginitis is seen most often in children between 2 and 7 years of age. Some genital discharges are not caused by infection or inflammation. The signs of nonspecific vaginitis are vaginal inflammation and discharge. The child may or may not have symptoms. The only complaint may be a yellowish stain on the child's underpants noticed by the mother. The character of the

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discharge, the appearance of the vaginal mucosa, and the child's symptoms do not help to identify the etiologic agent or the type of bacterial causing the infection.

8.0 Fissures

Superficial breaks in the skin or mucous membranes fissures may ooze blood and be painful. They heal completely and leave no sequelae unless they become infected in which case they may result in a small scar or an anal tag.

9.0 New or Healed Lacerations

Lacerations are deep breaks in the skin or mucous membranes of the vagina or anus. They often leave scar formation after healing.

10.0 Enlarged Hymenal Introital Opening

One criterion often used to make a diagnosis of sexual abuse is an enlargement of hymenal introital opening. A vaginal introital diameter of greater than 4 mm is highly associated with sexual contact in children les than 13 years of age. The size of the hymenal opening can vary with increasing age and pubertal development of the child. Other factors such as the position of the child during the measurement, the degree of traction placed on the external genitalia, and the degree of relaxation of the child can

influence the measurements. The nature of the abuse and the time elapsed since the abuse can also change genital findings.

11.0 Sexually Transmitted Diseases

Transmission of sexually transmitted diseases outside the perinatal period by nonsexual means is rare. Gonorrhea or syphilis infections are diagnostic of sexual abuse after perinatal transmission has been ruled out. Herpes type 2, Chlamydia, Trichomoniasis, and condyloma infections are extremely unlikely to be due to anything but abuse, particularly in children beyond infancy.

12.0 Sperm

If the abuse occurred within 72 hours, the physical examination may reveal the presence of sperm. The survival time of sperm is shortened in prepubertal girls because they lack cervical mucus; if there is a delay before an examination, the likelihood of finding sperm is diminished.

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D. PHYSICAL FINDINGS ASSOCIATED WITH ANAL SEXUAL ABUSE

Anal assaults comprise a significant proportion of child sexual abuse attacks. Genital injuries or abnormalities are more often recognized as possible signs of abuse, while anal and perianal injuries may be dismissed as being associated with common bowel disorders such as constipation or diarrhea. The anal sphincter is pliant and, with care and lubrication, can easily allow passage of a penis or an object of comparable diameter without injury. The anal sphincter and anal canal are elastic and allow for dilation. Digital penetration usually does not leave a tear of the anal mucosa or sphincter. Penetration by a larger object may result in injury varying from a little swelling of the anal verge to gross tearing of the sphincter. If lubrication is used and the sphincter is relaxed, it is possible that no physical evidence will be found. Even penetration by an adult penis can occur without significant injury. After penetration, sphincter laxity, swelling, and small mucosal tears of the anal verge may be observed as well as sphincter spasm. Within a few days the swelling subsides and the mucosal tears heal. Skin tags can form as a result of the tears. Repeated anal penetration over a long period may cause a loose anal sphincter and an enlarged opening. Physical indicators of anal sexual abuse include, but are not limited to,

1.0 Perianal Erythema

Reddening of the skin overlying the perineum as well as the inner aspects of the thighs and labia generally indicates that there has been intra crural intercourse (penis between legs and laid along the perineum). Erythema in this area, however, also results from diaper rash, poor hygiene, or after scratching and irritation from pinworms.

2.0 Swelling of the Perineal Tissues

Circumferential perianal swelling appears as a thickened ring around the anus and has been called the tire sign. It is an acute sign and can reflect traumatic edema.

3.0 Fissures

Breaks in the skin/mucosal covering of the rectum, anus, anal skin occur as a result of overstretching and frictional force exerted on the tissues. This can occur following passage of a hard stool or abusive traumatic penetration of the anus. Tiny superficial cracks in the verge or perianal skin often result from scratching with pinworms or with excoriation from acute diarrhea or diaper rash.

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4.0 Large Tears

Large breaks in the skin extending into the anal canal or across the perineum are usually painful and can cause anal spasm. Tears often heal with scarring and leave a skin tag at the site of the trauma.

5.0 Skin Changes

Repeated acts of penetration will lead to changes in the anal verge skin. Repeated friction and stretching of the fibers of the corrugated cutis and muscle results in thickening and smoothing away of the anal skin folds. The skin appears smooth, pink, and shiny, with a loss of normal fold pattern. The presence of these skin changes suggests chronicity of abuse. Scars are evidence of earlier trauma.

6.0 Funneling

Funneling is a traditional sign of chronic anal sexual abuse but its presence in children has been questioned. The appearance of funneling or a hollowing-out of the perianal area is caused by loss of fat tissue or fat atrophy of the subcutaneous area. Although this is often associated with chronic anal sex, it has also been described to occur in nonabused children.

7.0 Hematoma and/or Bruising

Subcutaneous accumulations of old and new blood and bruising are strong indicators of trauma. It would be very unlikely for these to occur without a history to explain them. These injuries are not likely to be accidental.

8.0 Anal Warts

Anal warts can occur as an isolated physical finding or in conjunction with other signs consistent with abuse, either anal or genital. Anal warts in children under age 2 years whose mother has a history of genital warts are most likely not the result of abuse. If no history of genital warts is elicited, the family should be evaluated for their presence. In children over 4 years of age with new genital warts, abuse should be considered and the child carefully interviewed by an experienced evaluator. Evaluation of genital warts is difficult in the nonverbal child.

9.0 Physical Findings & Abnormalities Mistaken for Anal Sexual Abuse

Perianal abnormalities are often seen in children with Crohn disease or Hirschsprung disease. The anal canal gapes in children with significant constipation. The distended rectum, with a normal anorectal reflex, initiates the gaping. Stool is often seen in the anal

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canal. Small fissures can also be seen. These children may have trouble with fecal soiling, which causes reddening of the perianal area. Unfortunately, children who were anally abused often suffer from functional constipation, which results in a damaged anal sphincter and fecal soiling. The pain and injury that follow the anal assault may cause spasm of the sphincter and result in functional constipation.

E. CONDITIONS THAT CAN BE MISTAKEN FOR SEXUAL ABUSE

- Lichen scierosis et atrophicus
- Accidental straddle injuries
- Accidental impaling injuries
- Nonspecific vulvovaginitis and proctitis
- Group A streptococcal vaginitis and proctitis
- Diaper dermatitis
- Foreign bodies
- Lower extremity girdle paralysis as in myelomeningocele
- Defects which cause chronic constipation, Hirschprung disease, anteriorly displaced anus
- Chronic gastrointestinal disease, Crohn disease
- Labial adhesions
- Anal fissures

Some dermatologic, congenital, traumatic, and infectious physical findings can be mistaken for sexual abuse. The most common dermatologic condition confused with trauma from sexual assault is lichen sclerosis. It can present in a variety of ways from mild irritation of the labia and vaginal mucosa to dramatic findings such as subepidermal hemorrhages of the genital or anal area involving the labia and vaginal mucosa and/or the anus. Monteleone, J., & Brodeur, A. Child Maltreatment: A Clinical Guide and Reference, 159 (G.W. Medical Publishing 1994).

B. COMMON QUESTIONS & ISSUES

These questions and answers are taken from Monteleone, J., & Brodeur, A. Child Maltreatment: A Clinical Guide and Reference, 159 (G.W. Medical Publishing 1994).

Can a child be born without a hymen to explain physical findings described?

There is no documented case of an infant girl born without a hymen.

Can excessive masturbation or the use of tampons explain abnormal vaginal findings?

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Masturbation and tampons do not cause injury to the hymen or internal genital structures. There is no evidence that use of tampons causes trauma to the hymen. Masturbation in girls usually involves clitoral or labial stimulation and does not cause hymenal injury. Children who masturbate excessively or insert foreign objects into body orifices usually show no genital or anal injuries.

Can a child contract a sexually transmitted disease by merely sharing the same bed, toilet seat or towel with an infected individual?

In general, as the title implies, sexually transmitted diseases are sexually transmitted.

Can horseback riding, gymnastics or dancing cause permanent genital changes?

Injuries can occur with physical activities. When such injuries involve the genitalia, the event is very dramatic and will be reported immediately. If a physician finds hymenal changes after a child has disclosed sexual abuse or during a routine examination, injury from one of these activities is not being investigated because it would not be a reasonable explanation for the changes.

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